No. 14,804

IN THE

United States Court of Appeals

For the Ninth Circuit

Peggy Ray Walker Kingston,
Appellant,

vs.

M. S. McGrath,
Appellee.

FILED

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APPELLANT'S REPLY BRIEF.

Tobriner, Lazarus, Brundage & Neyhart,
1035 Russ Building, San Francisco 4, California,

D. L. Carter,
Idaho First National Bank Building, Weiser, Idaho,

Attorneys for Appellant.

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OPENING STATEMENT.

This case is treated and discussed in appellee's brief as if there had already been a determination of the controversy in question after a trial on the merits which would have entitled him to all of the favorable inferences concerning conflicts and contradictions in the evidence under the ordinary rules on appeal. Thus, after rejecting appellant's statement of the case on the asserted ground that it is "incomplete and inadequate", appellee presents his version of the evidence. This is largely in the form of excerpts taken at random from the testimony, interpolated with appellee's comments as to their supposed significance. The transcript has been carefully sifted by appellee in the process, and there are very few references to any-

thing in the record tending to support appellant's contentions on this appeal. Much of the testimony actually presented in this myopic view of the evidence is, in fact, twisted and distorted with the same reckless disregard for accuracy shown by appellee at the trial of the case.

This is a closing brief, however, and we deem it unnecessary by way of rejoinder to categorically single out all of the many instances in which the evidence has been camouflaged and embroidered upon in appellee's brief. Specific reference to the numerous inaccuracies appearing therein will therefore be made here only where necessary to avoid confusion and misunderstanding. We are confident that in the final analysis, when the evidence is fairly considered and tested in accordance with the proper rules on appeal in a case of this kind, it will plainly appear that appellee's arguments are no stronger than the collapsible foundation of false assumptions upon which they necessarily rest.

ARGUMENT.

A.

APPELLEE'S BRIEF IGNORES THE RULE ON APPEAL FROM AN INVOLUNTARY DISMISSAL OR NONSUIT AT THE CONCLUSION OF PLAINTIFF'S CASE IN A TRIAL BY JURY THAT THE EVIDENCE IS TO BE TAKEN IN A SENSE MOST FAVORABLE TO APPELLANT.

In summarizing the testimony upon which appellant relies in our main brief, we referred first to the interpretation given by the authorities, including the

highest Court of the land, to Rule 41(b), Federal Rules of Civil Procedure, when invoked by a defendant on a motion to dismiss at the conclusion of plaintiff's case in a trial by jury. We carefully pointed out that the evidence, contrary to the usual rules on appeal, is to be regarded only in the light most favorable to plaintiff, and that the motion can therefore be properly granted only if the evidence, thus construed, is insufficient *as a matter of law* to justify a verdict for the plaintiff (Appellant's Opening Br. pp. 11-12).

The Federal rule is no different in this respect from the rule invariably followed by state tribunals to preserve the right to trial by jury on a motion for nonsuit. The effect of the motion has been well put by the Idaho Court as follows:

> "On a motion by the defendant for nonsuit after the plaintiff has introduced his evidence and rested his case, *the defendant must be deemed to have admitted all of the facts of which there is any evidence and all the facts which the evidence tends to prove.*" (Emphasis added).
>
> *Evans v. Bannock County* (1938), 59 Idaho 442, 449; 83 P. 2d 427.

A motion for nonsuit may properly be granted, therefore, only when disregarding conflicting evidence and giving plaintiff's evidence all the value to which it is legally entitled, indulging in every legitimate inference which may be drawn therefrom, the result is a determination that there is no evidence of sufficient substantiality to support a verdict for plaintiffs. The trial Court is not justified in taking the case from the

jury unless it can be said as a matter of law that no other reasonable conclusion is legally deducible from the evidence, and that any other holding would be so lacking in evidentiary support that a reviewing Court would be impelled to reverse it on appeal or the trial Court to set it aside as a matter of law.

As we clearly stated in our former brief, "for purposes of this review, conflicts must therefore be ignored, and the evidence, with all reasonable inferences resulting therefrom, must be regarded in a light most favorable to appellant's contentions." (Appellant's Opening Br. p. 12).

There were obviously many irreconcilable conflicts in the testimony adduced in this case. This was true even as to individual witnesses, notably, the appellee, Dr. McGrath, who, as we shall point out, gave testimony by way of deposition which was often incompatible with his recollection as to the same events on the witness stand.

With the above rule in mind, however, we purposely made no attempt in our former brief to relate evidence merely contradictory to the facts established by plaintiff's proof in support of her legal theories, and which, if accepted by the jury, would have entitled her to a recovery. We were entitled to disregard such evidence and to assume that any conflicts would be resolved in appellant's favor.

The selection from the transcript presented by appellee as a purported statement of the facts consists, on the other hand, largely of testimony favorable to

appellee and disputed by other evidence in the case which has been carefully ignored. It has been largely made, as will be shown elsewhere with little difficulty, from testimony developed by appellee's counsel which was either intended to refute facts previously established by plaintiff's witnesses, or for the purpose of laying the foundation for anticipated defenses. Much of this evidence, if given effect and allowed to prevail, would have undoubtedly tended to defeat plaintiff. It is not entitled to consideration for purposes of this appeal, however, and appellee has most certainly started with the wrong approach. In short, appellee, in attempting to usurp for his own benefit the favorable view of the evidence to which the appellant alone is entitled, has endeavored to give a reverse application to the rules by which the appeal is governed. This, although paradoxically, after abusing and completely disregarding the correct rule for sixty pages, appellee, by a token reference to the rule in the course of the concluding paragraphs in his brief, finally recognizes that it exists and acknowledges that it has been accurately stated in appellant's brief. (Appellee's Br. pp. 60-61).

There is another very fundamental misconception in appellee's brief concerning the probative effect of the testimony in this case that should be considered here. A very substantial part of the testimony singled out and quoted by appellee was testimony elicited by appellee's counsel during the examination of appellee and other defendants called as witnesses under Rule 43(b). Such testimony, however, even if it stood un-

contradicted, would not be binding upon appellant on this appeal. A party who calls an adverse party pursuant to Rule 43(b) *is not bound by the unfavorable testimony* of such party and it was so held in *Moran v. Pittsburgh Des Moines Steel Co.* (C.A. 3), 182 Fed. 2d 467, at page 471, wherein the Court stated:

> "Here, Jackson was called in the first place as an adverse witness under Rule 43(b), which expressly provides that such an adverse witness may be contradicted and impeached. Rule 43(b) we think is utterly inconsistent with any notion about being bound by his testimony."

The detailed consideration to the foregoing principles given here was made necessary to avoid any confusion that might otherwise result from the misleading manner in which the facts are presented in appellee's brief. The only contention made by appellee in his endeavor to justify the extraordinary ruling of the trial Court by which appellant has been denied her constitutional and statutory right to a trial by jury is the alleged insufficiency of the evidence. The record bearing on this question will therefore be reconsidered and viewed in its proper perspective.

B.

APPELLEE'S BRIEF COMPLETELY OVERLOOKS THE VERY SUBSTANTIAL EVIDENCE IN THIS CASE TO SUPPORT A FINDING OF MALPRACTICE IN CONNECTION WITH APPELLANT'S CARE AND TREATMENT, AND RELIES PRIMARILY ON DISPUTED EVIDENCE WHICH IT IS CLAIMED EXCUSES OR EXCULPATES HIM FROM RESPONSIBILITY FOR HIS PROFESSIONAL NEGLECT.

This is the case of the victim of an automobile accident who was brought to a modern and well-equipped hospital and placed under the care of a physician and surgeon, but was allowed to suffer excruciating pain until her 39th hospital day before her attending physician eventually discovered that her injuries included a broken neck, although he had suspected such an injury without making any real attempt to treat her for this condition. It is also a case in which the same patient was allowed to suffer from a broken back for 18 days without treatment, notwithstanding the fact that the possibility of compression injury was disclosed by an X-ray report received by her doctor a few days after he assumed responsibility for her care.

We stated in our opening brief that there was ample evidence from which the jury could have found the appellee guilty of malpractice on each and all of the following theories:

(a) Failure to exercise due care and skill in making his diagnosis of appellant's injuries, and not making proper use of available X-ray equipment and other diagnostic facilities.

(b) Negligence in the care and treatment of appellant's known injuries, and in failing to immobilize her

or otherwise protect her from further aggravation of her injuries until a more definite diagnosis could be made.

(c) Negligence and breach of duty in failing to inform appellant as to the serious character of her injuries, and in failing to suggest consultation with an orthopedist. (Appellant's Opening Br. p. 18).

An outline of the pertinent testimony upon which the foregoing conclusions are based was presented in our opening brief at pages 12 to 18, inclusive. Appellee is unable to claim, and his brief does not even remotely suggest, that there was the slightest inaccuracy in any of our statements concerning the evidence in this case. To the contrary, his criticism, as summed up at page 51 of appellee's brief, seems to be that we are said to have picked out "isolated statements" from the testimony of Dr. McGrath and other hostile witnesses "to justify the position of the appellant that there was evidence sufficient to carry her case to the jury" and that what we "did not say or point out is far more significant" than what we did. It turns out upon further analysis that what counsel really means is that we have had the temerity of refusing to accept or to give probative value to defendant's testimony in conflict with our own, or to testimony from adverse parties testifying under Rule 43(b). What appellee has blindly failed to understand throughout, however, is that this was not only our privilege, but also our duty if proper effect is to be given to the appellate rules under which this cause is to be submitted.

Thus, appellee in expressing his supposed grievances at page 52 of his brief states that "what counsel did not say was that three times Dr. McGrath tried to persuade appellant to let him put a neck brace on her and that she swore at him and said, 'I won't wear that thing'." This reference is, of course, to testimony given by Dr. McGrath, as a witness called under Rule 43(b), and, as we shall point out, was utterly contrary to testimony concerning the same incidents previously given by the plaintiff as a witness on her own behalf. Appellee obviously takes the absurd position that we had no right to reject or deny credence to anything said by the defendant on the witness stand, even though he is the defendant and his statements were merely contradictory in character and in the form of evidence elicited under Rule 43(b).

To continue with another example, appellee's brief rebukes us with the statement that "what counsel did not point out was that he (Dr. McGrath) had ice-packs placed on each side of the neck and tried to have them kept there, but the appellant would not tolerate that and would throw them out on the floor." The supposed conduct is completely at variance with the circumstances as they were explained in the testimony of the plaintiff, and our retort to this statement is the same as before.

By way of further reproach, but this time in a more sinister manner, appellee states that "what counsel did not point out was that as soon as the appellant had recovered sufficiently from the delirium tremens to be placed upon the X-ray table, this was done. . . ."

This statement is not only no more defensible than the others, but is more odious in that it assumes as a proven fact in this case that the respectable lady in question was addicted to alcoholism. The opinion testimony which the defendant doctor gave in a rather despicable attempt to avoid responsibility for his professional neglect is the only real evidentiary support for this calumny. Even if it had any basis in fact, which we vigorously deny, it would not constitute even a partial defense in this case.

We turn for a final example to the assertion in the concluding paragraph on page 52 that "what counsel did not point out was that Dr. McGrath had not only a seriously injured patient, but an uncooperative one." Most of the evidence in this case, including the hospital records, is, as we shall demonstrate, definitely to the contrary. Surely, however, the responsibilities of the medical profession are such as to require not less, but perhaps even greater, care for an intractable and unruly patient than for one who is meek and submissive.

We repeat, therefore, that what appellee would have us do is to cancel out all of the favorable evidence and accept only facts which are claimed to be shown by his own testimony as evidence in this case. This is a trap into which we do not choose to fall.

C.

THE EVIDENCE, WHEN FAVORABLY CONSIDERED, ENTITLES APPELLANT TO HAVE THE ISSUE OF MALPRACTICE SUBMITTED TO THE JURY UNDER PROPER INSTRUCTIONS COVERING EACH OF THE FOLLOWING THEORIES: (A) FAILURE TO EXERCISE DUE CARE AND SKILL IN DIAGNOSING HER INJURIES; (B) NEGLIGENCE IN THE CARE AND TREATMENT OF HER KNOWN INJURIES, AND (C) NEGLIGENCE AND BREACH OF DUTY IN FAILING TO OBTAIN CONSULTATION WITH AN ORTHOPEDIC SPECIALIST.

Because of the wrong emphasis that appellee has placed on the evidence in this case in his brief, we deem it necessary to enlarge our former statement by specific reference to some of the testimony upon which we rely for support. The questions raised by appellee's brief as to the existence of or necessity for expert testimony to entitle appellant to a recovery in this case will be discussed under another heading. In this recapitulation, the facts will therefore be considered in a general way and, under the applicable rules, in the light most favorable to appellant.

1. **There was substantial evidence to justify a jury finding that appellee failed to use the requisite care and skill in diagnosing appellant's injuries.**

Immediately upon her arrival at the hospital following the unfortunate accident that occurred on October 19, 1952, Dr. McGrath had X-rays taken of appellant's cervical spine, and also her chest and ribs. The doctor testified that he determined what X-rays should be taken and that they were obtained under his direction (R. 119).

She was still in a state of shock when she was later transferred to a private room, where she was

again examined by Dr. McGrath. He described her critical condition at this time in his testimony as follows:

> "Q. What were her complaints at the time you first examined her after she was taken to her room?
>
> A. Still complaining of *severe pains in her neck radiating up to the back of her head* and pains in the left side of her chest.
>
> Q. Did she give indications to you of being in very severe pain?
>
> A. Yes."
>
> (R. 121).

A few days later he received Dr. Morris' analysis of the first series of X-rays. This was the report in which the radiologist referring to the views showing the thoracic spine, stated that the "possibility of compression injury is not ruled out." Despite this very alarming possibility, however, Dr. McGrath made no further attempt to diagnose the nature of this injury whatever until November 5th, when he finally had another X-ray taken of the thoracic spine. The radiologist's interpretation of this film was received on November 6th, and it was not until then, after his unfortunate patient had been in the hospital for 18 days, that there was even the remotest attempt in the way of treatment or cure for her back injury.

The original X-rays of the neck were negative for bony pathology. A reason for this may very well be the one given in Dr. Bolker's report of November 26th:

> "A previous lateral view of the neck taken with the neck in extension produced a reduction of this dislocation fracture so that it was not apparent on examination of 10/19/52."
>
> (R. 156).

Be that as it may, no further attempt was made to use the X-ray as an aid to diagnosis of her neck complaints, which caused most of her intense suffering, even when she was on the X-ray table on November 5th for X-rays of her back, until the cervical films that were taken on November 18th. A final set of X-rays of the injured area were taken on November 20th and it was not until November 26th, her 39th hospital day, after the radiologist's report for this group of films was received, that there were any belated attempts at treatment for her broken neck.

The doctor's testimony showed that he was certainly aware of the ordinary symptoms of a cervical fracture:

> "Q. Now, assuming as it now appears, there was a neck fracture in this case, what are the usual symptoms of a neck fracture?
>
> A. Pain, may have instability of the head, may not be in proper position, or may or may not be angulation or asymmetry.
>
> Q. Unless there is some neurological signs, and by that I mean some paralysis, or some outward manifestation of the nerve injury, those would be about all the ordinary symptoms of a neck fracture; isn't that correct?
>
> A. That would be the major portion of them, majority of them."
>
> (R. 164).

Furthermore, Dr. McGrath testified that his knowledge of orthopedics was gained in large part from Key and Conwell, the authors of a well-known medical text entitled "Fractures, Dislocations and Sprains," and that this was the only authority on the subject with which he was familiar. (R. 253). He stated that he had therefore naturally evaluated this work, both in arriving at his conclusions on the case, and in connection with the opinions expressed by him on the witness stand. (R. 252-253). Several pertinent quotations from these eminent authors were therefore read into evidence, and this is what they have to say at page 381 of their text concerning the symptoms for recognizing cervical fractures:

> "Diagnosis of Fractures and Dislocations of the Atlas and Axis. The stiology and symptoms are those of other cervical dislocations and stiffness in the neck and fixation of the head in an abnormal attitude. If the patient is not paralyzed, he will *tend to support the head with the hands* and is unwilling to relinquish this support to another person. Sudden death may occur at any time from a sudden displacement of the head with a pinching off of the medulla. It is, of course, impossible to determine by physical examination whether or not the odontoid process is fractured in these upper cervical lesions. However, *such a fracture should be suspected if the patient has a marked sense of instability of the head on the neck."*
>
> (R. 258).

From the hospital records, the testimony of the witnesses, and the fact that she did have a broken

neck, it is apparent that the foregoing symptoms were present during all of this time. Her own testimony in this regard is as follows:

> "Q. Getting back to this neck condition; will you describe that in more detail as to the type of pain it was, and what difficulty, if any, you had?
>
> A. Well, that night when I told them my neck hurt so bad, and complained about my neck, Doctor McGrath wanted to slide one of those things over my head, but the pain just was excruciating. I just couldn't stand it, couldn't even let him touch my head was so sore. It *kept getting worse every day,* the pain in my head.
>
> Q. Now did you tell the doctor this first time on the first examination about the pain and condition of that?
>
> A. Oh, yes, Mr. Lazarus.
>
> Q. Were you able to move your neck about all right?
>
> A. No, no. *I had to pick my head up to move it from one spot on the pillow to the other.*"
>
> (R. 45, 46).

> "A. Every time I told Doctor McGrath—'Doctor McGrath, my neck, I can't stand it, I can't stand it,' he said to me, 'Those are bruises and when bruises come to the surface they hurt worse.' He then said they were deep bruises coming to the surface.
>
> Q. Now on the following day, Monday, without taking it hour by hour, will you describe the condition you observed and felt generally through the day on Monday? What complaints did you have generally on Monday?

A. I felt worse. *I felt worse every day.*

Q. Did you have intense pain of any kind?

A. I had this pain—*most of the pain was here in the back of my neck, and shooting up into my head.*

Q. *Did you still have difficulty in moving your head or neck?*

A. *Oh, I couldn't.*"

(R. 48).

"Q. Now did you tell the Doctor about your complaints on your second hospital day, or Monday?

A. Yes, Mr. Lazarus, *every day I was in the hospital I complained.*

Q. Now did this neck condition improve the third day?

A. No, *it got worse.*"

(R. 49).

"Q. Now after you came out of this condition you referred to, what about the condition of your neck, was there any difficulty there?

A. *My neck kept getting worse every day,* Mr. Lazarus.

Q. Do you have pain elsewhere besides in the area of the neck area?

A. All of this side. Of course, I thought it was ribs, whatever it was here from my back and across here (indicating)—my left side.

Q. Did you continue to inform the doctor as to these complaints?

A. Yes."

(R. 53).

Mrs. Sidney Cox testified to the following observations during the time that she visited her sister when she had her hallucinations:

> "Q. Did she make complaints as to her physical condition?
>
> A. Oh, yes, her pain—she kept saying, 'My pain, Sidney, I can't stand it, help me.'
>
> Q. Where was she complaining of the pain?
>
> A. In her neck. *She held it at the time.*"
>
> (R. 395).

> "Q. Now the complaints during Saturday, the last day you were there on this trip, did she continue to make these complaints?
>
> A. Yes, sir, it was her neck, her neck, and every minute, 'Sidney, it is my neck, something is wrong.' "
>
> (R. 397).

Dr. McGrath, in fact, "suspected she probably had a fracture" (R. 124) and his provisional diagnosis appearing in the hospital record under date of October 19th was: "Severe shock, fracture 1st and 2nd cervical vertebrae and 6th dorsal, multiple bruises and abrasions." (Pltf's. Exh. 1.) Later, after receiving the negative X-ray films of this part of her anatomy, he "began to feel she *possibly* didn't have a fracture in the cervical region." (R. 142).

He admitted that it was standard practice in the hospital, moreover, to continue to treat the patient's symptoms, although X-rays taken as an aid to diagnosis for possible fractures might be negative.

"Q. Now it is a fact, is it not, that in the treatment of a patient where X-rays have been taken as an aid to diagnosis for possible fractures that if the X-rays are negative that the doctor still continues to treat the symptoms, isn't that correct?

A. If the patient will allow you to, yes.

Q. And that would be the standard practice in the hospital in which you were connected?

A. Yes, you couldn't force your treatment on to any individual."

(R. 164, 165).

Obviously, from the evidence, the doctors in the Weiser Memorial Hospital knew, as does everyone else, that X-rays, while a most valuable aid in diagnosing fractures, are far from infallible, and that follow-up films should always be taken when suspected fractures are not disclosed by the original X-rays. Dr. Coats' testimony in this regard was as follows:

"Q. Can you say on the basis of your experience whether or not the initial X-rays taken in the case of bone injury always demonstrate the existence of a fracture?

A. Not always, no."

(R. 287).

"Q. I believe you said it is true that an X-ray doesn't always disclose fractures?

A. That is correct.

Q. But if an X-ray doesn't disclose a fracture, what do you do about it?

A. *You would certainly get more X-rays."*

(R. 301).

"Q. In other words, if a negative X-ray in a fracture case, and there was nothing else of any particular consequence that came to your attention in the treatment of the patient, you would accept that finding of the radiologist; wouldn't you?

A. That is right.

Q. But on the other hand, if in your treatment of the patient you observed symptoms and complaints, it would indicate that notwithstanding any negative X-ray film there was still maybe some serious condition, I take it you would take more film; is that correct?

A. Yes."

(R. 312).

Under the authorities cited and considered in our opening brief at pages 24 to 33, the failure of a physician and surgeon to make proper use of X-ray facilities as an aid to diagnosis in cases of doubt, renders him responsible to the patient for all injuries and damage resulting therefrom. Many of these cases involve neglect in the failure to take follow-up X-rays where indicated for proper diagnosis and treatment. Appellee's brief does not question the legal principles established by these decisions, and the standards of care that they require on the part of members of the medical profession is conceded without argument here. Indeed, as we shall further point out, appellee's brief admits by implication the duty of a doctor to make adequate use of available diagnostic facilities in treating his patient, but relies almost entirely on opposing evidence which he claims, if accepted, would excuse

his failure to make proper use of the X-ray in the instant case. How then can it be said that appellant did not produce evidence entitling her to have the matter of liability submitted to the jury under this theory of her case, if the formidable testimony that we have outlined above is to be favorably regarded?

The supposed exculpatory facts upon which appellee bases his defensive arguments may be summed up as follows:

(a) The claim that Dr. McGrath is protected by the negative report concerning the original X-rays taken of appellant's neck, and that he was thereby entitled to close his eyes to the situation with which he was thereafter confronted, and the torment which was understandably suffered by his patient. (b) The argument that she was in a state of shock and in such a painful condition that it would have been imprudent to have her placed on the X-ray table. (c) The aspersion that she was suffering from delirium tremens, and that she could not therefore be subjected to the restraint necessary to take additional X-rays.

While testimony of this kind, intended by way of justification of appellee's conduct, might have been properly considered by the jury in deciding this case on its merits, it has no validity for purposes of this appeal under the appellate rules that we have again been obliged to emphasize in the preliminary part of this brief. This, as we have already pointed out, is because it was in the nature of anticipated defenses to meet the *prima facie case* established by plaintiff,

it was in conflict with plaintiff's evidence and came almost entirely from witnesses called under Rule 43(b). Although we would be entitled to therefore completely disregard any evidence in support of these contentions in this proceeding, we nevertheless, for purposes of this argument, intend to assume the unnecessary burden of showing that even if it was entitled to be weighed along with other evidence in the case, it would not support the conclusions contended for by appellee.

The argument that a doctor who has a critically injured patient on his hands, a patient who might be permanently crippled or whose life might be momentarily snuffed out by the slightest movement because of suspected fractures of the spinal column, can disregard the X-ray as a further means of diagnosis merely because a few X-rays hastily taken at the beginning of the case did not disclose the suspected fractures just doesn't make sense. The role that the X-ray has played in saving human life and in preventing deformities from broken bones has made this marvelous discovery one of the greatest boons in the history of mankind. But every layman as well as every doctor knows that this three-dimensional form of photography by which medical science has now been able to project shadowy images of the human skeleton into a camera is often far from perfect in its results. Frequent X-rays of even the larger bones of the anatomy are often taken before the radiologist can detect what are afterwards found to be rather conspicuous fractures. Even among the experts, one

radiologist will often find anomalies that were completely overlooked by another.

Some of the factors affecting the value and quality of the results, such as positioning and technique, were touched upon in the testimony of Dr. Morris and may be found in the record at pages 319 and 320.

The problems in getting good X-ray pictures of the cervical spine are even more difficult than usual because of the contour and small size of the vertebrae and bony processes. The particular care necessary to endeavor to discover fractures in this region by X-ray is well shown by the following statement from Key and Conwell, read into evidence by Dr. McGrath:

> "In taking x-ray pictures of the atlas and axis, lateral pictures are taken in the usual manner, while antero-posterior pictures are taken *through the wide open mouth.* It is important when taking them through the mouth to so direct the rays that the shadow of the occiput does not impinge upon that of the upper cervical vertebrae. The tendency is to slant the x-rays too far upward and backward, with the result that the occiput clouds the picture of the first and second cervical vertebrae. For this reason they should be carefully directed in such a manner that they run parallel with a line drawn from the edges of the upper incisor teeth to the base of the occiput."
>
> (R. 259).

The two X-rays of the neck taken by Dr. McGrath were a lateral and an anterior-posterior view. One

of the many reasons why these photographs may not have revealed the fracture is indicated by the portion of the report of Dr. Bolker referred to above. Another may very well be that the anterior-posterior X-ray taken by Dr. McGrath on October 19th was not taken through the mouth, and presumably the rays were not slanted as recommended by Drs. Key and Conwell.

The fact that Dr. McGrath knew that the possibility of neck fractures could not be ruled out on the basis of the report on the X-rays taken on October 19th is clearly indicated by the circumstance that when he finally decided to again use the X-ray as an aid to diagnosis on November 18th he had *six* views taken of the neck and skull (R. 332). Even with this number, the radiologist's report, after noting certain anomalies, stated that "it is believed that the odontoid process is intact." (R. 153). It was not until the report was received in connection with the final series of *four* pictures taken on November 20th that the multiple fractures were definitely established by X-ray evidence.

And what excuse does Dr. McGrath give for not bothering to take follow-up X-rays? We quote his testimony:

> "Q. Well, you knew as a practicing surgeon and physician, did you not, that X-ray views, particularly of the cervical area because of the bones and everything are not always an infallible method of diagnosis; did you not?
>
> A. The radiologist did not recommend I take any more films."
>
> (R. 135).

Appellant placed herself under the care of her physician and surgeon, not the radiologist. How would Dr. Morris know that any further X-ray films were indicated when it is admitted in the testimony of Dr. McGrath that he never at any time notified Dr. Morris that the same aggravated complaints and symptoms that indicated the possibility of serious neck injury still continued? (R. 137). The doctor cannot shift his obligations to his patient to the radiologist, and if he was still in doubt after receiving the initial X-rays, he owed it to his desperately injured patient to use the means at hand for a more definite diagnosis. If Dr. McGrath had a patient who had all the symptoms of a broken neck, did he have any right to rule out this possibility merely because the two X-ray films which he, himself, directed to be taken did not confirm his provisional diagnosis?

To paraphrase the language quoted from *Stagner v. Files* (1938), 182 Okla. 475, 78 P. 2d 418, at page 30 of our former brief, *if the circumstances were such as to create any doubt as to whether or not appellant may have had fractures of her cervical spine, the defendant was negligent in failing to use the methods known to him by which the extent of her actual injuries could have been discovered.*

The argument that appellant was in a state of shock and was in no condition to have X-rays taken is likewise untenable, and may be quickly disposed of. Dr. McGrath testified that she was only in shock for three or four hours, and on her second hospital day she was no longer in shock (R. 123). If the doctor

now claims that she was in such agony that she could not safely be placed on an X-ray table, this is certainly not the impression that he had after she was in the hospital for a few days, according to appellant's testimony.

> "Q. Now did the doctor make any statements to you with regard to your condition, any subsequent statements around the third or fourth day?
>
> A. Except that I should be able—as soon as I could walk I could do down to a hotel in Weiser, rest there, and then I could go on home.
>
> Q. The first three or four days were you able to get up and walk around at all?
>
> A. I tried to walk around the bed and I *would hold my head*. In fact, I did that for weeks and weeks, and tried to walk because my legs were getting weaker all the time. You can't lie in bed and get strong."
>
> (R. 49).

In any event, in so far as her neck was concerned, it would have been a very simple matter to have taken X-rays of that part of her anatomy *when she was on the table to have her back X-rayed on November 5th.* Dr. Bolker was the regular staff radiologist for the hospital and he visited there every Wednesday. If there were any problems in connection with obtaining further X-rays, presumably he could have been consulted, but this was never done.

The final and complete answer, however, is that no matter what appellant's condition was, the hospital was equipped with *portable X-ray equipment* which, if necessary, could have been moved to her bedside,

if Dr. McGrath was as solicitous about the ordeal of placing her on the X-ray table again as he says he was (R. 121, 286-287). A broken neck is certainly a very painful injury, and the argument made by appellee is tantamount to saying that follow-up X-rays should never be taken in a case where a fractured cervical spine is suspected.

We come now to the contemptible insinuation that the delirium that manifested itself after appellant had been in agony in the hospital for several days without anything being done for her care or cure other than to drug her with opiates was what is commonly known as delirium tremens. This scurrility is predicated solely upon so-called opinion testimony given by Dr. McGrath, solicited by questions put to him by his own counsel while he was on the witness stand under Rule 43(b).

All of the direct evidence on this subject is to the effect that this reputable lady never indulged in alcoholic beverages except in the form of an occasional social drink, and then in moderation (R. 104-105, 406, 438-440). The best proof of her sober habits is in the fact that she was continuously employed in a responsible position by a large and very conservative San Francisco firm for 17 years (R. 38-39).

Admittedly appellant had more drinks than she would customarily take on the Saturday night that was to wind up her vacation in Idaho. But instead of the carousal pictured in appellee's brief, here is what actually took place as the events of that evening were more accurately portrayed by the testimony of appellant:

"Q. Isn't it a fact that every night—let's say practically every night, you and Soden and others there drank in both of those bars, in Council?

A. Of course, by drinking, Mr. Martin, I don't know exactly what you mean. Do you mean I had a cocktail before my dinner and a few drinks during the evening while I danced, if that is what you mean, I did.

Q. How many drinks would you have after dinner?

A. When you are supposed to be enjoying yourself you don't count them.

Q. You didn't keep track of them, did you?

A. Four or five.

Q. All right, maybe more?

A. I doubt it very much.

Q. And you drank until one o'clock when the bars closed?

A. I did what?

Q. You would drink there and stay in those bars until one o'clock in the morning when they closed?

A. Not every night, Saturday night I did."

(R. 92, 93).

This, then, is the extent of the debauchery that appellee would have us believe occurred on appellant's last night in Idaho. It is also significant that despite the attempt to create the impression by the Rule 43(b) testimony of Dr. McGrath that his patient had an alcoholic breath when she was brought to the hospital, there is no mention of this in any way in the hospital records. This, although the records kept at the Weiser Memorial Hospital were very detailed and exact, and included all of the usual entries.

There is no doubt that on the evening of appellant's fourth hospital day she became delirious and developed hallucinations as described in the nurse's entries in the hospital records. This lasted for a few days. At the end of that time she became quite rational again. The following entry was made by the nurse on duty on October 25th, her sixth hospital day: "Patient completely oriented today. Is aware of all her confusion yesterday and is eager to be cooperative." Typical entries for the next few succeeding days are: "Good day" and "Resting well".

Mrs. Cox testified that when she went to the hospital to see her sister on Saturday morning, October 25th, she appeared to be perfectly normal again (R. 397), and that Dr. McGrath came into her room and after an examination said: "Your sister is all right now." (R. 398). The statement on page 17 of appellee's brief that "appellant had suffered from the delirium tremens over this period of some *two weeks*" is therefore a compound fabrication.

It is common knowledge that there are many forms of delirium that follow severe injury or, more often, as we learned from our war experience, from fatigue or anxiety. Dr. McGrath's testimony indicates that the only experience that he has had with delirium, however, is the brand suffered by the common drunks attended by him in the county jail. Dr. McGrath, in his unwarranted assault on appellant's character, would place appellant in the same category.

Why, if Dr. McGrath believed that his patient was suffering from delirium tremens, did he not indicate

his findings by an appropriate entry in the hospital record? Could it be that this was merely a convenient afterthought, a diagnosis made after he became a defendant in a lawsuit?

Let us suppose, however, that the appellant instead of being the respectable and decent business woman that she was, was a weak and unfortunate tippler who had sunk to the depths of dipsomania. Let us suppose that she was, in fact, suffering from delirium tremens. The fine traditions of our medical profession are such that the wretched and the lowly can expect the same consideration from their medical attendant as those who have not succumbed to human frailty. If there was any problem about putting her on an X-ray table during the few days that her delirium was acute, why then wasn't something done after she was restored to normalcy? Why, with an X-ray report indicating that his patient might have a broken back, did Dr. McGrath wait until November 5th before taking additional X-rays of the thoracic spine? And above all, why did Dr. McGrath wait until the 18th day of November before making use of the X-ray as an aid to diagnosis for her neck condition?

2. There was substantial evidence to justify a jury finding that appellee was negligent in the care and treatment of appellant's known injuries.

Dr. McGrath certainly knew how imperative it was to take immediate steps to immobilize possible fractures, or other serious injuries of the neck. This undoubtedly appears from the following testimony:

"Q. And now, Doctor, you knew at that time, of course, that if it was a suspected neck fracture or serious injury to the neck it was very vital and important to immobilize the area, did you not?

A. Yes, I attempted to.

Q. I didn't get that.

A. I attempted to immobilize.

Q. But you knew that was very important to do, did you not?

A. Sure, any injury to the neck it is very important to immobilize.

Q. The reason for that, is it not, Doctor, because unless injuries of the neck, particularly fractures, are immobilized promptly considerable damage to nerves, nerve roots, cord and surrounding tissue could be done; is that correct?

A. That is very possible.

Q. And you knew it too, did you not?

A. Yes.

Q. That is, Doctor, as a matter of fact, *it is a matter of common knowledge in the medical profession, almost universal knowledge that neck injuries or suspected fractures should be immobilized; am I correct in that regard?*

A. *That is correct.*

Q. And I think you have already stated the reasons for it because of the possibility any movements of that very mobile part of the skull might cause further serious damage; isn't that correct?

A. Yes, sir."

(R. 159, 160).

Presumably he also consulted the medical text that he made use of in orthopedic cases before undertaking to treat a serious case of this kind, and, if so, he

found the following statements that were later read into evidence from Key and Conwell:

> "In all fresh dislocations and fracture dislocations the patient should be handled with extreme care because *one of the most important considerations is to protect the spinal cord from further damage,* and unguarded movements or manipulations on the part of the patient or surgeon may result in severe damage to the cord or even death. For this reason the patient should be placed immediately on a stretcher or hard bed without a pillow under the head, but with the sandbags or hard pillows on either side of the head, and should be moved with great care."
>
> (R. 254).

> "It is unwise, however, to attempt to make the diagnosis of such a dislocation by physical examination; for when a dislocation or fracture dislocation of the atlas and axis is suspected, great care should be taken not to subject the patient to injudicious manipulations. He should be placed on a bed or stretcher at the earliest possible moment with the head in a position of hyperextension *supported by sandbags."*
>
> (R. 258, 259; emphasis added).

Let us look to the transcript again, therefore, to see what, if anything, was done by Dr. McGrath to comply with these elementary requirements for the proper treatment of serious neck injuries. He claims in his brief that he did, in fact, endeavor to immobilize the injured area. He also raises, in addition to the affirmative defenses that have already been discussed, the contention that he was unable to render proper treat-

ment because he had an obstreperous and uncooperative patient on his hands. He also argues that there were more immediate concerns in connection with the treatment of his patient which excused him from doing anything further. Since we are not bound by his testimony, we are considering it here solely for purposes of this discussion, and we do not wish to be understood as conceding that it has any more weight than that to which it is entitled.

His testimony discloses that the most that might have been done by him in an endeavor to immobilize appellant's injuries was to place icebags alongside of her neck and to try to persuade her to wear a cervical brace of some kind that he had in his office.

There is no doubt from the hospital records that one or more ice bags were for some reason placed alongside plaintiff's neck at the beginning of her stay in the hospital. It is a matter of general knowledge that ice bags are commonly used in cases of injury to relieve pain and swelling.

The voluminous hospital records evidencing the treatment received by appellant at the Weiser Memorial Hospital include two pages of instructions given by Dr. McGrath for the guidances of the nurses on duty. It is strange, is it not, that if Dr. McGrath felt that her neck should be immobilized by the use of ice bags, or by any other means, no directions in that regard were included in his instructions?

We have also carefully scanned the entries in the nursing record for any references that they may

contain concerning ice bags. The only pertinent notations that we have been able to find during the period in question are as follows:

1st hospital day, 1:00 A.M.: "Ice bag to neck"

1st hospital day, 12:30 P.M.: "Ice caps to side of neck"

1st hospital day, 5:00 P.M.: "Ice caps to sides of neck"

3rd hospital day, 6:30 P.M.: "Ice cap to neck"

This is all. Two of these entries indicate that only one ice bag was applied, which could not have possibly been for the purpose of immobilization. Also, the nurses kept a very careful record of everything else done by the patient which should be known to her treating physician. If appellant had been a recalcitrant patient who threw away ice bags which her doctor had ordered to be kept in place to safeguard her from further injury, surely some notation of this lack of cooperation would have been found in the nursing record.

We next refer to the argument that Dr. McGrath discharged his duty to safeguard and protect his patient from further injury when he endeavored to persuade her to wear the neck contraption. According to plaintiff, the only time that the doctor ever suggested that she wear a brace was on the first night in the hospital when Dr. McGrath "wanted to slide one of those things over my head, but the pain was just excruciating. I just couldn't stand it, couldn't even let him touch my head it was so sore." (R. 46).

The doctor denied by his testimony that he made any attempt to apply the brace, but in his version of the evidence stated that he merely "showed it to her and explained to her what it was for." (R. 126). He testified at the trial that he attempted to do this on three different occasions during the first two days of her confinement (R. 184), although he recalled only two such occasions when his deposition had been previously taken (R. 241-244). Be that as it may, it is admitted by his own testimony that *after the second hospital day he abandoned all further attempts to immobilize her injured neck.*

> "Q. Did you at any time subsequent to the second hospital day, I believe it was, put this neck brace or harness, whatever it was, on her?
> A. No, sir.
> Q. Now did you ever suggest it to her again?
> A. No, sir."
> (R. 146, 147).

With all of the facilities available to him in this modern hospital, the doctor was thereafter heedless of his patient's misery and did not take a single step in the way of alleviative or protective measures. He made no attempt to use sandbags or traction, or to put her in plaster of Paris, nor did he even endeavor to have her fitted with a more suitable kind of neck brace. He did not warn her of danger or advise her of the seriousness of the situation, and permitted her to walk around with knowledge of the possibility that she had a broken neck (R. 141). The statement on page 47 of appellant's brief that what Dr. Loutzen-

heiser did immediately upon appellant's return to San Francisco in placing her cervical spine in traction was exactly what Dr. McGrath wanted to do with appellant on the first or second day she was in the Weiser Memorial Hospital is an absolute and unmitigated falsehood.

The argument that the doctor was confronted with a patient who was ungovernable and difficult to handle may be very quickly disposed of. This ridiculous supposition is not only unsupported by any evidence in the case, but is completely refuted by the following entries in the nursing records:

6th hospital day: "Eager to be as cooperative and pleasant as possible."

7th hospital day: "A good day"

9th hospital day: "Had good day"

10th hospital day: "Pt. rational seems quite cheerful"

11th hospital day: "A good day"

12th hospital day: "Up in chair. Tolerated very well."

13th hospital day: "Patient very pleasant and cheerful."

16th hospital day: "Pt. very talkative and cheerful."

(Pltf's. Exh. 1).

It is remarkable, indeed, that a patient in her condition and so completely neglected by her attending physician could maintain the tolerant and agree-

able disposition evidenced by the foregoing hospital entries. What more in the way of cooperation could Dr. McGrath expect from a lady who without medical aid was enduring the tortures of a broken neck?

Finally, we have no quarrel with the refrain running throughout appellee's brief that the responsibility of a physician and surgeon is to treat his patient first, and the injuries in their due time. We fail to see where it has any application here, however. Except, perhaps, for the first few days that she was in the hospital, all that the doctor had to look after was her broken back and her broken neck. How long was she to wait until the doctor got around to treating the very injuries that were responsible for her hospitalization?

Even if there had been some other undisclosed condition that made it imperative for Dr. McGrath to "take care of his patient first", this would still be no answer. It would have been his duty to attend to her other injuries just as soon as conditions permitted, as pointed out in the following language from the leading case of *Weintraub v. Rosen* (C.C.A. 7, 1938), 93 F. 2d 544, cited and strongly relied on in our opening brief:

> "It may be conceded that the injury to her head prevented an examination and treatment of her hip sooner than five days after the injury. However, this record discloses that the patient was in a condition to undergo an examination of her hip when she regained consciousness * * * We may safely assume from the evidence, therefore,

that appellees were negligent in not observing the condition of the patient's hip."

3. There was substantial evidence to justify a jury finding of negligence and breach of duty by appellee in failing to obtain consultation with an orthopedic specialist.

Appellee is a general practitioner, and without reviewing the evidence in that regard, we may safely assume from the testimony that appellee's knowledge and experience in the field of orthopedic injuries was very limited. Since spinal fractures are a particularly serious type of injury, requiring prompt and very skillful treatment, it unquestionably appears that he would under ordinary circumstances refer such cases to a specialist for treatment. This is his testimony in that regard:

> "Q. Now, Doctor, in general practice, for example, do you treat cases involving fractures of various bones of the body?
>
> A. Sometimes.
>
> Q. When you say 'sometimes' I take it that there are certain types of cases you wouldn't?
>
> A. That is right.
>
> Q. Have you treated prior to the time that the plaintiff in this case came to the Weiser Hospital, or was brought to the Weiser Hospital, have you treated cases involving spinal fractures?
>
> A. Fractures I would refer to other doctors.
>
> Q. Then, as I understand you correctly, usually in a case where you have known or suspected spinal fractures you would then call in some specialist?

A. A known spinal fracture.

Q. What type of specialist would you call in on that type of a case?

A. Orthopedic surgeon.

Q. If it was a case where the patient was confined in a hospital would you have the specialist come to the hospital?

A. If the patient so desired.

Q. Now on these cases where you treated the spinal fractures where you felt you ought to call in a specialist, where would you have to call a specialist from?

A. Boise.

Q. Can you tell us approximately how many miles Boise is from Weiser?

A. It is 85 or 90 miles."

(R. 115, 116).

"Q. When you discovered from reading the X-ray on the 26th that there was a fracture of the odontoid process of the neck, and of the lamina of the first *first* cervical vertebrae, did you consider that an injury that called for treatment by a specialist?

A. Yes, when I received that report I did.

Q. How is that?

A. When that report was received I did. In fact, I had called him before I received the report.

Q. You figured that was an injury a little too far over in the book for an ordinary practitioner?

A. Yes."

(R. 219).

However, although he was asked on a number of occasions in the instant case about the advisability of calling in someone else, he declined to do so. Appellant testified that she got nowhere when she mentioned to him before her back injury was definitely diagnosed that perhaps "two heads are better than one" (R. 447-448). Mrs. Sidney Cox testified to the conversation that she had with the doctor during the first week that her sister was in the hospital when she said to him, "Dr. McGrath, I am terribly worried about my sister, don't you think it might be well if we could call another doctor in." The emphatic response that she recived was that there was "nothing to worry about" (R. 396). Appellant's son, Gardner P. Wood, testified that when he obtained a furlough to visit his mother on about November 18th or 19th, and after seeing the condition in which she then was, he said to the defendant, "Dr. McGrath, don't you think it advisable to get another doctor, just look at my mother, I don't like the looks of her," but received the same kind of evasive reply.

The above facts would appear to come squarely within the rule mentioned in our quotation at page 22 of our opening brief from *Tevedt v. Haugen* (1940), 70 N.D. 338, 294 N.W. 183. The *Tevedt* decision, as we also mentioned in our former brief, is the case that was so firmly approved and extensively quoted by the Idaho court in *Flock v. J. C. Palumbo Fruit Co.* (1941), 63 Idaho 220, 118 P. 2d 707. One of the principal grounds for the decision in the

Tevedt case was that a doctor who knows that he does not have the experience or facilities to properly treat a patient and that the services of a specialist are available and would be advisable, has a duty to call this to the attention of the patient. To put it another way, a doctor who, with knowledge of the fact that he does not have the requisite skill or training to undertake a particular kind of treatment ordinarily performed only by experts, cannot by concealing this from his patient escape responsibility for bad results.

D.

THE EVIDENCE ENTITLING APPELLANT TO HAVE THE ISSUE OF MALPRACTICE SUBMITTED TO THE JURY UNDER EACH OF THE FOREGOING THEORIES WAS, IN FACT, SUPPORTED BY EXPERT TESTIMONY.

Appellee's brief states flatly at page 61 that "appellant has not pointed to one scintilla of medical testimony to support his contention that he should not have been non-suited". This presupposes, of course, that such evidence was necessary in this case, which we do not concede. It is undoubtedly the general rule in malpractice cases that where the applicable standards depend upon knowledge of the scientific effect of medicine, or the result of surgery, they can only be shown by expert testimony of physicians and surgeons. This rule applies only to such facts as are peculiarly within the knowledge of such professional experts, however, and not to matters of gen-

eral knowledge of which the courts may take judicial notice.

Appellee cites *Huffman v. Lindquist,* 37 Cal. 2d 465, 234 P. 2d 34, and other cases to like effect, in support of the ordinary rule. It might be pointed out that in the *Huffman* case the Court said (p. 474):

> "While in a restrictive class of malpractice cases the court have applied the doctrine of res ipsa loquitur, that has only been where negligence on the part of the doctor is demonstrated by facts which can be evaluated by resort to common knowledge [and] expert testimony is not required since scientific enlightenment is not essential for the determination of an obvious fact."

We will show in the section of our brief that follows this discussion that, at least in so far as negligence in assembling data essential for a correct diagnosis is concerned, this case comes within one of the well-recognized exceptions to the expert opinion rule. What appellee none the less overlooks, however, is that there was indeed considerable expert evidence to support each of the foregoing theories of recovery.

In that connection, we mention first something of importance that appellee has evidently failed to bear in mind. We refer to the fact that the expert testimony, where required to establish plaintiff's *prima facie* case, may be that of the defendant doctor called to the witness stand as an adverse party.

Dickow v. Cookinham (1954), 123 C.A. 2d 81, 266 P. 2d 63;

McCurdy v. Hatfield (1947), 30 C. 2d 492, 183 P. 2d 269;

Lashley v. Koerber, 26 Cal. 2d 83, 156 P. 2d 441;

Bowles v. Kinton, 83 Colo. 147, 263 P. 26;

Jacobs v. Grigsby, 187 Wis. 660, 205 N.W. 394.

The California Supreme Court put it this way in the *McCurdy* case (p. 495):

> "The negligence of the doctor may be established by his own testimony elicited under section 2055 of the Code of Civil Procedure. (*Lashley v. Koerber, supra; Lawless v. Calaway, supra.*) Although the defendant here did not expressly refer to the practice followed by other doctors in the community, he did testify as to what was proper practice, and *it is reasonable to infer that his testimony was based on the standard of care used by physicians in the locality.* If he failed to conform to the proper practice as set forth in his testimony, he did not act as a reasonable physician should under the circumstances." (Emphasis added).

We now meet appellee's challenge by confronting him with the following references to some of the very formidable evidence of an expert character in this case. We have already pointed out the testimony coming from Dr. McGrath and Dr. Coats indicating that it was "standard practice in the hospital" to take more X-rays when the possibility of fracture still appeared, notwithstanding a negative report in earlier films. Of course, as irrefutably shown by this evidence, a doctor would not stop his efforts to make a proper diagnosis and to heal his patient, merely because no anomalies were detected in the first

X-rays taken in the case, and nothing more need be said on that subject here.

With regard to the failure to immobilize appellant's neck injury, Dr. McGrath by his own testimony, also referred to above, admitted that he knew at the time that it was vital and important to immobilize such injuries, and that it was a matter of "almost universal knowledge in the medical profession" that neck injuries or suspected fractures should be immobilized. This also plainly appears from the testimony of Dr. Coats, not to mention the rudimentary principles of practice set forth in Key and Conwell which the doctor says were evaluated in treating his patient.

It is likewise an inescapable conclusion from the testimony already set forth that it is the sound practice of general practitioners on the staff of the Weiser Memorial Hospital, including appellee, to call in specialists in cases of spinal fractures, a practice that Dr. McGrath did not choose to follow in this instance until too late, although it had been suggested by appellant and members of her family.

We turn now to the expert evidence from which it may be reasonably inferred that because of Dr. McGrath's neglect the consequences of appellant's injuries were much more serious than otherwise, and resulted in permanent deformity that could no longer be remedied.

We have already quoted the testimony of Dr. McGrath that he knew that the reason for taking every precaution to immobilize the neck was "because un-

less injuries of the neck, particularly fractures, are immobilized promptly considerable damage to nerves, nerve roots, cord and surrounding tissue could be done". This probability is also shown by the testimony of Dr. Coats and the statements from Key and Conwell appearing in the record.

With regard to the broken back, Dr. McGrath testified that it was a fact that a compression fracture of the thoracic area usually changes the curvature of the spine and that such curvature, depending upon the amount of bone absorption, can not normally be corrected unless it is treated promptly (R. 162). He also gave testimony from which it may be freely inferred that the longer a fracture of this kind continues without treatment, the greater the damage from movement of the fragments and impingement upon the nerve (R. 250-251). There was similar testimony coming from Dr. Coats (R. 295-298, 308-309).

Dr. Loutzenheiser testified in his deposition that when he finally saw appellant the odontoid process was displaced about 15 degrees. He testified that an attempt to straighten out the upper spine by the use of traction was partially successful, but that "because seven weeks had elapsed since date of injury" he was unable to take the procedures necessary to make any correction in the thoracic spine (R. 370-371).

Appellee's brief makes the further point that none of the physicians who testified in this case mentioned Dr. McGrath by name, or condemned him or criticized

the procedures followed by him directly. The reluctance of one doctor under the exacting code of ethics followed by the medical profession to comment on the treatment rendered by another is very well known, and this is really expecting too much. Where expert testimony is required in a malpractice case, it is only for the purpose of establishing the proper standards of treatment. This can be shown by circumstantial evidence and it is not necessary for the witness to sit in judgment on his fellow-practitioner. The conclusions to be drawn from the surrounding circumstances are within the sole prerogative of the Court or jury. This distinction was aptly pointed out recently in the case of *Norden v. Hartman* (July, 1955), 134 A.C.A. 371, 375, 285 P. 2d 977:

> "The ultimate question which a jury must answer, and the question which an expert may answer for the purpose of furnishing evidence upon which the jury is to make up its mind, are not identical. Professional witnesses may testify concerning the teachings of their science and the customs of their craft, *but whether these things disclose due care presents a question for the court or jury.*" (Emphasis added).

E.

APPELLEE IGNORES THE AUTHORITIES CITED IN APPELLANT'S BRIEF IN SUPPORT OF THE WELL-ESTABLISHED EXCEPTION TO THE GENERAL RULE IN MALPRACTICE CASES THAT THE USE OF X-RAYS AS AN AID TO DIAGNOSING POSSIBLE BONE INJURIES IS A MATTER OF COMMON KNOWLEDGE, OF WHICH THE COURTS WILL TAKE JUDICIAL NOTICE WITHOUT THE INTRODUCTION OF EXPERT TESTIMONY.

The use of the X-ray has become such standard practice in the diagnosis and treatment of suspected bone injuries that, as unequivocally stated in many of the cases cited under the heading appearing on page 24 of our main brief, the Courts will take judicial notice of this requirement without the aid of expert testimony. Where such a failure is the basis for a claim for malpractice, it is therefore only necessary to produce evidence from which it might reasonably be inferred that the defendant doctor did not make proper use of available X-ray facilities in connection with his diagnosis and treatment of the patient to establish a *prima facie* case.

The most complete statement of the doctrine by the California Courts is in *Agnew v. City of Los Angeles,* 82 C.A. 2d 616, 619, 186 P. 2d 450 (failure to take X-rays that would have disclosed that the patient had a broken hip):

> "This is the sole question for our determination:
>
> "In view of the fact that there was no expert testimony that Dr. Larson had failed to use that degree of skill and learning ordinarily possessed by physicians of good standing practicing in the

community where he resided, would the foregoing facts if believed by the trial judge make a prima facie case in favor of plaintiff sufficient to require the denial of defendant's motion for a nonsuit?

"This question must be answered in the affirmative.

"[1] *General Rule.* The law requires that a physician shall have that degree of skill and learning ordinarily possessed by physicians of good standing practicing in the same locality, and that he shall use the same care and diligence in applying that learning to the treatment of a patient. [2] It is likewise the general rule that whether he has done so in a particular case is a question for experts and can be established only by their testimony. (*Trindle v. Wheeler,* 23 Cal. 2d 330, 333 [143 P. 2d 932].)

"[3] *General Exception.* To the above general rule there is this well-recognized exception, to wit, where the question of the propriety of the treatment is a matter of common knowledge of laymen, expert testimony is unnecessary in order to establish liability in a malpractice case.

"[4] *Specific Exception.* The use of the X-ray as an aid to diagnosis in cases of fracture or other indicated cases is a matter of common knowledge, and the failure to make use thereof in such a case amounts to a failure to use that degree of care and diligence ordinarily used by physicians of good standing practicing in this community. *The court in the absence of expert testimony may take judicial notice of this fact.* (Citations).

> "[5] It is evident in the present case that when plaintiff fell a possible fracture was indicated, and under the foregoing rules it is likewise apparent that *it was a matter of common knowledge, of which the trial court should have taken judicial notice that the ordinary physician of good standing in this community, in the exercise of ordinary care and diligence, would have had X-ray pictures taken of plaintiff's body when a fracture might have resulted from the fall.* In failing to do so defendant did not exercise the degree of learning and skill ordinarily possessed by physicians of good standing practicing in this community. Defendant Larson thus failed to use ordinary care and diligence in his treatment of plaintiff, with the result that plaintiff suffered personal injury. Therefore, the evidence which plaintiff introduced before the trial court established a *prima facie case* and it was error to grant defendant's motion for a nonsuit." (Emphasis added).

In the *McBride* case (*McBride v. Saylin,* 6 C. 2d 134, 56 P. 2d 941, another leading California decision, plaintiff consulted a general physician and surgeon for treatment of an injury to his eye, which had been struck by a nail. Some time later, it was found that there was a foreign body in the eye and the plaintiff lost the sight of that orbit. There was testimony that the customary means used by physicians and surgeons to determine the presence or absence of a foreign body in the eye are an ophthalmoscope and the X-ray. Neither instrument was used by the defendant doctor for purposes of examination. The Court said:

"Under the settled law of this state this evidence was sufficient to prove a *prima facie* case. (*Estate of Lances,* 216 C. 397 [14 P. (2) 768].) The legitimate inference which may be drawn from it is that Dr. Bulpitt should have suspected the presence of a foreign body in the eye; that he failed to exercise that degree of care which the practice of his profession requires, *in failing to make such examination as would make reasonably certain that there was nothing in the eye;* and that this was the proximate cause of the serious and unfortunate injury to plaintiff. The evidence would support such findings, and the action of the trial court in granting the motion for a nonsuit was unwarranted." (Emphasis added).

The same rule has been consistently followed by other Courts, and without repeating what has already been said concerning those decisions in our former brief, we refer particularly to the following cases:

Wilson v. Corbin (1950), 241 Ia. 500; 41 N.W. 2d 702;

Weintraub v. Rosen (C.C.A. 7, 1938), 93 F. 2d 544;

Stagner v. Files (1938), 182 Okla. 475; 78 P. 2d 418;

Kuhn v. Banker (1938), 133 Ohio St. 304; 13 N.E. 2d 242;

Flock v. J. C. Palumbo Fruit Co. (1941), 63 Idaho 220; 118 P. 2d 707.

Nor do the principles enunciated by these decisions apply only, as appellee infers without reference to

authorities, to situations in which the doctor has completely neglected to have any X-ray pictures taken. His responsibility to his patient is a continuing one, and he is under no less an obligation to take follow-up X-rays when indicated for proper diagnosis, and the cases cited by appellant so hold.

In the *Reynolds* case (*Reynolds v. Struble* (1933), 128 C.A. 716; 18 P. 2d 690), analyzed and discussed in our opening brief at pages 24 to 26, it was pointed out that the fact that the doctor had previously taken an X-ray which did not disclose the injury to his patient's arm was no excuse. The Appellate Court declared in its decision that the circumstances known to him "required *further* examination and the taking of *further* X-ray pictures to determine the true condition of the patient", and held that the court could take judicial notice of these requirements.

The factual context for the decision by the Iowa Court in *Wilson v. Corbin,* supra, was set forth at page 28 of our opening brief. There, X-rays taken the day after the plaintiff entered the hospital likewise did not show that he had a fractured vertebra. His physician was held liable, however, because during the six days that he thereafter remained in the hospital his physician, in the face of complaints that his pain did not subside, took no other X-rays and made no further examination. In addition to the language quoted on page 29 of our former brief concerning judicial notice of the requirement for adequate use of the X-ray as an aid to diagnosis of bone injuries, the Court had the following to say:

"Dr. Stindler testified compression fractures of the spine are frequently caused by such a fall as plaintiff's and that *location of the pain and history of the injury are important in indicating a compression fracture.* As stated, defendant was told about the fall and the resulting pain. Defendant's assistant Dr. Buchtel (whose deposition, taken by defendant, was offered by plaintiff) said *the pain of which plaintiff complained in his lower back and hips 'certainly did' create suspicion of a compression fracture* and in a fall like plaintiff's compression fractures may occur in the lower dorsal or any of the lumbar vertebrae."

* * * * * * *

"It seems almost self-evident that delay of nearly three months in diagnosing and treating a fractured vertebra would naturally cause damage. As stated in Wambold v. Brock, supra, 236 Iowa 859, 763, 19 N.W.2d 582, 585, 'In fact, *it is a matter of common knowledge that bone injuries, particularly fractures, should receive prompt attention.'* " (Emphasis added.)

The facts of the Ohio case recognized and cited by the Idaho Supreme Court as authority in *Flock v. J. C. Palumbo Fruit Co.,* supra, (*Kuhn v. Banker* (1938), 133 Ohio St. 304, 13 N.E. 2d 242) were summarized in our former brief at page 27. There, a number of X-rays had been taken by the defendant physician at various times during the early stages of treatment. The Court held however that the plaintiff was entitled to have the issue of negligence submitted to the jury on the basis of evidence that later on,

when she still complained of pain and grating in her leg, the doctor did not take additional X-rays to see if there was a proper union.

Indeed, appellee has not only ignored the authorities cited in our brief, but has without reason entirely misconstrued our position. He states, at page 58 of his brief, for example, that "while the appellant's brief does not contain any legal proposition to the effect that she invoked the doctrine of res ipsa loquitur, the argument and the entire brief indicates an attempt to do so." Appellee is in error and has built up an imaginary claim that has never been made. We have never invoked the res ipsa loquitur doctrine in this case. In arriving at this unwarranted conjecture, appellee has obviously confused the doctrine with the rule dispensing with the necessity of producing expert testimony to establish a *prima facie* case of malpractice where the circumstances relied upon are matters of common knowledge and experience, of which the Courts can take judicial notice.

CONCLUSION.

The same superficial attention has been given to the law in appellee's brief as was done in presenting the supposed facts. The cases cited in appellant's opening brief were completely by-passed by appellee without the slightest comment or criticism. None of the decisions referred to by appellee, on the other hand, dealt with situations that were even remotely similar

in fact or principle to those with which we are here concerned.

Presumably, since this is a case in which Federal jurisdiction is based upon diversity of citizenship, state law is to govern. It is to be noted, therefore, that appellee's brief refers to only three decisions by the Idaho courts, to wit, *Evans v. Bannock County,* 59 Idaho 442, 83 P. 2d 427; *Reinholdt v. Spencer,* 53 Idaho 688, 26 P. 2d 796, and *Willis v. Western Hosp. Ass'n.,* 67 Idaho 435, 182 P. 2d 950. It is difficult to see what solace appellee can find in any of these adjudications.

In the *Evans* case, the defendant hospital and physician were sued on the supposition that alcohol was used instead of novocaine during a herniotomy. However, all of the witnesses in the case testified that novocaine was used, and there was no evidence that alcohol had been injected. The reviewing Court therefore correctly sustained a judgment of nonsuit for the reason that plaintiff could not recover upon mere surmise or conjecture.

Counsel's reason for citing the *Reinholdt* case is even more difficult to understand. That was an appeal from an order denying defendant's motions for a nonsuit and directed verdict in a case where a hypodermic needle was left in plaintiff's chest. One of the grounds for the motions was that there was no competent evidence to show "that respondent suffered damage from or by reason of any act of negligence on appellant's part." The Appellate Court said, in affirming the judgment:

> "Damages, if any, flowing from an injury such as respondent sustained, that is, for pain and suffering and loss of income due to the particular injury, are susceptible to proof *only with an approximation of certainty, and it is solely for the jury to estimate them as best they can by reasonable probabilities* based upon their sound judgment as to what would be just and proper under all of the circumstances, which may not be disturbed in the absence of some showing that the jury were biased or prejudiced or arrived at the amount in some irregular manner." (Emphasis added.)

(citing a number of Idaho cases and also *Reynolds v. Struble,* the California case that is cited and discussed at pages 24 to 26 of our former brief, and upon which we strongly rely).

The *Willis* case involved an appeal from a judgment of nonsuit in a wrongful death action. The appellate court affirmed with the following assertion:

> "There is absolutely no competent substantial evidence to support appellant's allegation that the death of the deceased was due to the wrongful and negligent acts of the respondent while he was in the hospital at Orofino, or that his death was accelerated or in any manner contributed to by the acts or treatment he received while in said hospital."

While many California decisions are also cited in appellee's brief, none of them seem to have any application to the facts of this case. One of these authori-

ties, *Lashley v. Koerber,* 150 Pac. 272, cited and quoted in appellee's brief at pages 39, 31 and 55, can not even be found in the official reports of this state. This is because a hearing in that case was thereafter granted by the Supreme Court, which arrived at a contrary decision in *Lashley v. Koerber,* 26 C. 2d 83, 157 P. 2d 441, cited in our opening brief. Incidentally, the doctor in the *Lashley* case claimed that he knew that the plaintiff had a fractured finger when he first treated her, and that X-rays would have merely been a confirmation of his clinical judgment regarding possible fracture. He also testified that out of eight doctors in general practice in the community, seven of them had indicated that it was their custom to treat such fractures without invariably demanding an X-ray. It was held by the Supreme Court, however, in reversing a judgment of nonsuit by the trial Court, that the question as to whether or not the doctor had exercised a reasonable degree of skill and learning under the circumstances was a jury question.

Finally, appellee endeavors in his brief to create the impression that he is practicing medicine in a remote and isolated village, whose inhabitants had no right to expect the kind of skill and facilities for treatment that might normally be deemed proper. Actually, as shown by his own testimony, Weiser not only has a new and up-to-date hospital, but it is also the largest city in Washington County (R. 115). This argument completely vanishes, however, in the face of what was said by the Idaho Supreme Court in *Flock v. J. C. Palumbo Fruit Co.,* supra:

> "*Physicians are required to keep abreast of and use the best modern methods of treatment, and in so doing they may not unduly and narrowly restrict or confine their responsibility to the immediate place where they are practicing.* We may take *judicial notice* that the distance between Payette and Boise is in the neighborhood of 65 miles, that the facilities at Boise are readily accessible to the respondent employee . . ." Emphasis added.)

It is our earnest belief that we have clearly demonstrated that the judgment of the trial Court denying to appellant her fundamental right to a jury trial has resulted in a miscarriage of justice, and that in accordance with law and the evidence the judgment should therefore be reversed.

Dated, San Francisco, California,
January 27, 1956.

Respectfully submitted,
TOBRINER, LAZARUS, BRUNDAGE & NEYHART,
D. L. CARTER,

Attorneys for Appellant.